

304.17A-264 Coverage under health benefit plan for cancer screening, test, or procedure.

- (1) As used in this section:
 - (a) "Cancer screening, test, or procedure" means any preventive screening, test, or procedure performed for the purpose of detecting cancer, including but not limited to lung, breast, cervical, prostate, and colorectal cancer; and
 - (b) "Health benefit plan" has the same meaning as in KRS 304.17A-005, except that for purposes of this section the term includes:
 1. Short-term limited duration coverage; and
 2. Student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure.
- (2) Except as provided in subsection (3) of this section:
 - (a) All health benefit plans shall provide coverage for:
 1. Any cancer screening, test, or procedure that is required under federal law, including but not limited to 42 U.S.C. sec. 300gg-13, as amended; and
 2. Any other cancer screening, test, or procedure that is:
 - a. Consistent with nationally recognized clinical practice guidelines, including but not limited to:
 - i. The recommendations of the United States Preventive Services Task Force;
 - ii. Clinical practice guidelines established by the American Cancer Society; and
 - iii. Clinical practice guidelines established by the National Comprehensive Cancer Network; and
 - b. Ordered or prescribed by a health care provider legally authorized to order or prescribe the cancer screening, test, or procedure; and
 - (b) The coverage required under this subsection shall not be subject to:
 1. Utilization management requirements, including prior authorization, except for the purpose of determining that the cancer screening, test, or procedure meets the requirements of paragraph (a)2.a. of this subsection; or
 2. Any deductible, coinsurance, copayment, or other cost-sharing requirement.
- (3)
 - (a) If the application of any requirement of subsection (2)(b)2. of this section would be the sole cause of a health benefit plan's failure to qualify as a Health Savings Account-qualified High Deductible Health Plan under 26 U.S.C. sec. 223, as amended, then the requirement shall not apply to that health benefit plan until the minimum deductible under 26 U.S.C. sec. 223, as amended, is satisfied.
 - (b) If the application of any requirement of subsection (2) of this section to a

qualified health plan as defined in 42 U.S.C. sec. 18021(a)(1), as amended, would result in a determination that the state must make payments to defray the cost of the requirement under 42 U.S.C. sec. 18031(d)(3) and 45 C.F.R. sec. 155.170, as amended, then the requirement shall not apply to the qualified health plan until the cost defrayal requirement is no longer applicable.

- (4) (a) This section shall not be construed to limit coverage:
1. Provided under a health benefit plan; or
 2. Required under any other law.
- (b) In the case of a conflict between this section and any other law, this section shall control unless application of this section would result in a reduction of coverage or benefits for any insured.

Effective: January 1, 2025

History: Created 2024 Ky. Acts ch. 75, sec. 1, effective January 1, 2025.

Legislative Research Commission Note (1/1/2025). 2024 Ky. Acts ch. 75, sec. 5, provides that the amendments to this statute in that Act shall apply to health benefit plans issued or renewed on or after January 1, 2025.